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CONSENT FOR EXTRACTION OF TEETH AND ANESTHESIA

You have the right to be informed about your planned surgery so you can make a knowledgeble decision regarding your treatment. It is your right to understand all your treatment options including no treatment. I voluntarily request Dr. Woodmansee and other health care providers to treat my condition which has been explained to me as:

My planned treatment is: Surgical Extraction #_____

I understand that my doctor may encounter or discover conditions that are different from what has been described. These scenarios may require additional or different procedures than those planned. I authorize my doctor and other health care providers to perform any necessary procedures in their best professional judgement. Such issues or complications may result in loss of time from work or school and may incur additional expenses, including, but not limited to expenses for doctors, other dentists, or medical facilities.

I have chosen Dr. Woodmansee from all options I was offered to perform my dental surgery. I recognize that Dr. Woodmansee is a general dentist that is not employed by my dentist, but is an independent contractor.

In addition to risk associated with not having treatment on my present condition, there are also risks associated with the surgical treatment I have elected. Common risks associated with any surgical procedure include swelling, bruising, pain, bleeding, and infection. In addition to those risks, I also realize the following uncommon but possible risks associated with my particular procedure:

_____1. Possible damage to other teeth close to the ones being taken out, this usually happens to teeth with large fillings or caps.

_____2. Numbness, pain, or unusual feeling in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the proximity of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain is temporary, but in some cases, it may need more treatment or be permanent.

_____3. Jaw joint (TMJ) soreness, tenderness, pain, or locking which can be temporary or permanent.

_____4. Sometimes tooth roots may be left behind to avoid harming important things such as nerves or a sinus (a hollow place above your upper back teeth).

_____5. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment.

_____6. It is extremely rare that the jaw will break, but it is possible when the teeth are buried very deep in the jaw bone.

ANESTHESIA

I have had the opportunity to speak with Dr. Woodmansee about my options for anesthesia. These options include local anesthesia, nitrous oxide analgesia with local anesthesia, oral medication with local anesthesia, conscious intravenous sedation, or deep sedation/general anesthesia (being completely asleep). After this discussion, I have chosen to have conscious IV sedation ("twilight sleep") as my anesthesia. I understand the risks and potential complications of anesthesia. I understand that IV conscious sedation is a serious medical procedure and whether given in a hospital or office, carry the risk of respiratory problems, paralysis, brain damage, stroke, heart attack or death.

MY OBLIGATIONS:

Because anesthetic or sedative medications (including oral premedication) cause drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours. During recovery time (normally 24 hours), I should not drive, operate complicated machinery/devices, or make important decisions such as signing documents, etc.

_____7. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK, INCLUDING WATER, for **six (6) hours** prior to my treatment (water only is acceptable up to 2 hours prior). TO DO OTHERWISE MAY BE LIFE-THREATENING.

_____8. I have been given written and oral post-operative instructions. **I will personally contact Dr. Woodmansee in the event I have an issue**. I agree to follow his instructions until my issue has been satisfactorily resolved

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery and chosen anesthesia. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form. In signing, I believe I have sufficient information to give consent.

_____ _____ _____

Patient's Name (Please Print) **Patient's (or Legal Guardian's) Signature** **Date**

_____ _____

Doctors Signature **Date**